AIDS Medi-Cal Waiver Program
NOTICE OF ACTION (NOA)
DENIAL/REDUCTION/TERMINATION OF AIDS MEDI-CAL WAIVER BENEFITS

Name _____ **Date of Notice** _____

Address _____ **Date Services Expire** _____

_____ **Medi-Cal I.D. #** _____

Waiver I.D. # _____

Medi-Cal regulations allow for the provision of certain AIDS Medi-Cal Waiver Program (MCWP) Home and Community-Based Services (HCBS) to persons who meet specific criteria. We have taken the following action with respect to services requested for the reasons noted:

___ 1. Denied your application or ended services for causes such as program noncompliance or personal safety of caregivers or agency staff, specifically _____.

___ 2. Denied your application or ended services because you do not meet eligibility requirements as follows:

☐ You have not submitted adequate proof of Medi-Cal eligibility, your Medi-Cal eligibility cannot be verified or you are not eligible or no longer eligible for Medi-Cal.

☐ Your medical condition and/or medical needs do not currently meet the Nursing Facility or higher level of care and/or your diagnosis of asymptomatic HIV or AIDS-related medical condition, does not meet eligibility requirements, or your "CFA score" (the Cognitive and Functional Ability Scale) on the evaluation form that is used was too high.

___ 3. Denied and/or reduced some portion of the services requested. Your medical condition and/or medical needs have improved, necessitating a change in services ordered.

___ 4. Continuing to provide HCBS to you is not cost effective (i.e., the estimated cost of providing you with those services exceeds cost guidelines set by the State).

___ 5. Cost of services provided to you has reached the $13,209 calendar year annual cost cap. No more AIDS Medi-Cal Waiver services can be provided to you this calendar year.

___ 6. The services you need are fully available to you through private insurance, Medicare, Medi-Cal, or another program.

___ 7. You no longer desire HCBS.

___ 8. Other_____

This NOA is required by Code of Federal Regulations, Title 42, Chapter IV, Subpart E, and the California Code of Regulations, Title 22, Section 51014.1. You have the right to ask for a State Hearing (SH) if you disagree with any MCWP action. You only have ninety (90) days to ask for a hearing. The 90 days start the day after the MCWP gave or mailed you this notice. See page 2 for your appeal rights.

Denial or termination of AIDS MCWP benefits will not affect other medical or social services you are eligible to receive through California's Medi-Cal Program or other public benefit programs.

You may reapply for AIDS MCWP benefits at a future time if you believe you have become eligible.

Please call me for further information or if you have any questions. I may be reached at (_____)_____.

Sincerely,

_____ _____

Agency Representative Agency Name

STATE HEARING NOTICE - YOUR RIGHT TO APPEAL THE "NOTICE OF ACTION"

State Hearing Instructions--If you do not agree with the action described, you may request a State Hearing before an Administrative Law Judge employed by the California Department of Social Services (CDSS). This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your case manager can help you request a hearing. If you decide to request a hearing, you must do so within 90 days of the date of this notice. Your benefits will only continue until the *Services Expiration Date* listed at the top of page 1 which is at least 10 days from the date of this notice. If you are currently receiving AIDS MCWP services and you request a SH before the **Date Services Expire** indicated at the top of this notice (within at least 10 days after the date of this notice), you will continue to receive services until a SH decision is made. If you are currently receiving AIDS MCWP services and you request a SH after the **Date Services Expire**, your AIDS MCWP services will stop on the **Date Services Expire**. You must verbally notify your case manager if you file an appeal within this 10-day period.

If you wish to request a SH, please complete the attached *Request for a State Hearing* form and mail it to the address listed below or call the phone number provided. You must provide all the information on the form; any information missing from the request form may delay the processing of your request. If you ask for a hearing the State Hearings Division (SHD) will set up a file. You have the right to see this file before your hearing and to get a copy of the AIDS waiver provider's written position on your case at least two days before the hearing. The SHD may give your hearing file to the California Department of Health Services and the United States Department of Health and Human Services per Welfare and Institutions Code Sections 10850 and 10950.

How to Request a State Hearing—You must either complete the attached *Request for a State Hearing* **form and mail it to:**

California Department of Social Services
State Hearings Division
MS-19-37
744 P Street
Sacramento, CA 95814

Or call

Toll-Free Number: (800) 952-5253
Teletypewriter (TTD) only: (800) 952-8349

"Your Rights" Pamphlet Available--"Your Rights under California Welfare Programs" pamphlet issued by CDSS, provides useful information about State Hearings. This pamphlet will be sent to you when your hearing request is processed.

Authorized Representative--You can represent yourself at the State Hearing or be represented by a friend, attorney, or any other person; but, you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit (PIAR) at (800) 952-5253.

The PIAR office can also provide further information about your hearing rights. Assistance is available in languages other than English, including Spanish.

Code of Federal Regulations, Title 42, Section 431.220, Subpart E, Chapter IV, and the California Code of Regulations, Title 22, Section 51014.1, require that this **Notice of Action/State Hearing Notice** be mailed at time of denial of an application when it is determined that you are not eligible for waiver services or at time of reduction or termination of existing services. The Notice must be mailed **at least 10 calendar days** (excluding the mailing date) before the effective date of reduction or termination of services.

REQUEST FOR A STATE HEARING

Name	**Medi-Cal I.D. Number**
Address	**City**

I am requesting a State Hearing because of Medi-Cal related action by _____, an AIDS Medi-Cal Waiver agency related to the following reason(s):

- ❑ Denial of my application or ending of services for causes such as noncompliance or personal safety of caregivers or agency staff **OR**
- ❑ Denial of my application or ending of services because I do not meet eligibility requirements **OR**
- ❑ Denial and/or reduction of some portion of the service(s) requested **OR**
- ❑ Ending of services because it is no longer cost effective to do so **OR**
- ❑ The costs of services provided have reached the $13,209 calendar year annual cost cap **OR**
- ❑ Denial of my application or ending of services because services I need are fully available through private insurance, Medicare, Medi-Cal, or another program **OR**
- ❑ I no longer desire Home and Community Based services.
- ❑ Other_____

Describe the basis for your appeal below:

_____

_____

_____

- ❑ I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Language:	Dialect:

- ❑ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

Name: _____ Phone Number:_____

Street Address: _____

City: _____State_____ Zip Code_____

Signature: **Date:**

Mail to: California Department of Social Services
State Hearings Division
MS-19-37
744 P Street
Sacramento, CA 95814
Toll-Free Number: (800) 952-5253
Teletypewriter (TTD) only: (800) 952-8349

The AIDS Medi-Cal Waiver Program is administered by the Community Based Care Section, Office of AIDS, Department of Health Services, MS 7700, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.